September 11, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1616-01-SS

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient has undergone an MRI that showed disc disease at the L4-5 and L5-S1 levels. An X-Ray series showed severe degenerative changes at the L5-S1 and grade I spondylolisthesis at the L4-L5 level. The diagnoses for this patient include spondylolisthesis and disc displacement. The patient has been treated with extensive conservative treatment, epidural blocks and physical therapy.

Requested Services

Posterior Laminectomy decompression, posterior interbody fusion with bone graft & instrumentation L4-S1 with two-day inpatient length of stay.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a female who sustained a work related injury to her back on ___. The ___ physician reviewer also noted that the diagnoses for this patient include spondylolisthesis and disc displacement. The ___ physician reviewer further noted that the treatment for this patient's condition has included extensive conservative treatment, epidural blocks and physical therapy. The ___ physician reviewer indicated that the plain films provided did not support evidence of neural or foraminal encroachment in conjunction with the spondylolithesis. The ___ physician reviewer explained that the documentation provided did not demonstrate that the patient had failed non-operative care.

The ___ physician reviewer also explained that the documentation provided did not support the diagnoses of instability or any qualification of instability. Therefore, the ___ physician consultant concluded that the requested Posterior Laminectomy decompression, posterior interbody fusion with bone graft & instrumentation L4-S1 with two-day inpatient length of stay is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 11th day of September 2003.